SF 4400-DEN # (9-99)

Supersedes (8-99) issue

[redacted]

Sandia National Laboratories

(Please Read Instructions On Next Page Before Completing This Form.)

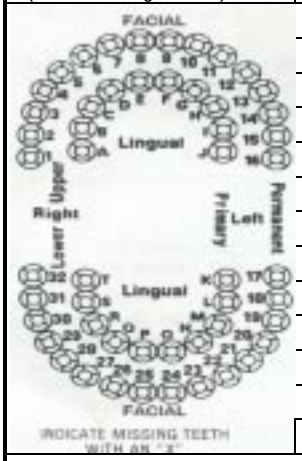
# Dental Expense Claim Form

| 1. Patient Name First Middle Last | 2. Relationship to Covered Person: Self ☐ Spouse ☐ Child ☐ Other ☐ | 3. Sex: M ☐ F ☐ | 4. Married: Yes ☐ No ☐ | 4. Patient Date of Birth: Mo Day Year | 6. Report Number: **2149839** |
|---|---|---|---|---|---|
| 7. If Full Time Student (Age 19 or Over) School City State | 8. If Disabled (Age 19 or Over) ☐Yes ☐No | 9. Covered Person's Soc. Sec.Number | 10. Name of Group: **Sandia National Laboratories** | | |
| 11. Covered Person's Name First Middle Last | 12 Covered Person's Date of Birth | 13. Office Phone (area code) | | | |
| 14. Covered Person's Residence Mailing Address | 15. City, State, Zip | | | | |
| 16. Are other Family Members Employed? ☐ YES ☐ NO Name Soc. Sec. No. | 17. Date of Birth | 18. Name and Address of Employer in Item 16 | | | |
| 19. Is patient covered by another dental plan? ☐ NO ☐ YES (If Yes, Complete the Following) Dental Plan Name | Group No. | Name and Address of Carrier | | | |
| 20. I Authorize Release of any Information Relating to this Claim. Signed (Patient, or Parent if Minor) Date | 21. I Certify that the Above Information is Correct. Employee Signature Date | 22. I Authorize Payment Directly to the Below Named Dentist. Employee Signature Date | | | |

| 23. Dentist Name | 31. Is Treatment Result of Occupational Illness or Injury? | No ☐ | Yes ☐ | If Yes, enter brief description and dates |
|---|---|---|---|---|
| 24. Mailing Address | 32. Is Treatment Result of Auto Accident? | ☐ | ☐ | |
| City, State, Zip | 33. Other Accident? | ☐ | ☐ | |
| 25. Dentist Soc. Sec. No. or T.I.N. / 26. Dentist License No. / 27. Dentist Phone No. | 34. Are any Services Covered by Another Plan? | ☐ | ☐ | |
| | 35. If Prosthesis, is this Initial Placement? | ☐ | ☐ | (If No, reason for replacement) 36. Date of prior placement |
| 28. First visit date Current Series / 29. Place of Treatment: Office ☐ Hosp ☐ ECF ☐ Other ☐ / 30. Radiographs or Models enclosed? ☐ Yes ☐ No / How Many? | 37. Is Treatment for Orthodontics? | ☐ | ☐ | If Services Already Commenced, Enter: / Date Appliance Placed / Mos. Treatment Remaining |

Dentist's
☐ Pre-Treatment Estimate
☐ Statement of Actual Services:
*(Be Sure to Sign Below)

31. Examination and Treatment Plan-List in Order From Tooth No. 1 Through Tooth No. 32 Use Charting System Shown




| Tooth # or Letter | Surface | Description of Service (Including X-Rays, Prophylaxis, Materials Used, Etc.) Line No. | Date Service Performed Mo | Day | Yr. | ADA Procedure Number | Fee | For Carrier Use Only |
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I Hereby Certify That The Services Listed Above ☐Will Be ☐Have Been Performed

Date

*Signed (Dentist)

Total Fee Actually Charged

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

MM8930.SCR(04/99)

MetLife

MetLife

## Information for Employee

1. Complete your section of the claim form (items 1 through 21) in full to assure positive identification and prompt payment. Please print or type. Note that item 8 (employee social security number) **must be completed** for the claim to be processed.

2. The **patient** (or parent if patient is a minor) must sign item 20.

3. You must sign the claim form in item 21.

4. You can arrange for Metropolitan to make payment directly to the dentist by completing item 22. If you wish benefits to be paid directly to yourself, do not complete item 22. In either case, a statement of benefits paid will be sent to you.

5. If total charges for the planned course of treatment are expected to be $200 or more, the form should be completed and submitted to Metropolitan **prior to the commencement of the course of treatment** for a pretreatment estimate of benefits. Metropolitan will notify you of the benefits payable.
   (If you wish, a pretreatment estimate may be requested for anticipated dental expenses of less than $200.)

6. If total charges for the planned course of treatment will be less than $200, the claim form should be completed when treatment is completed and mailed to the address shown below.

**Dental coverage is subject to specific limitations and exclusions. Please refer to your booklet for a description for covered services, schedule of benefits payable, limitations and exclusions.**

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## Information for Attending Dentist

1. Benefits are payable in accordance with four Classes of Services. It is therefore important that a separate fee is indicated for each item of service performed.

2. If total charges for a completed course of treatment are less than $200, check the box noted “Statement of Actual Services” and complete items 23 through 38. The claim form should then be sent to the address shown below.

3. If total charges for a course of treatment are expected to be $200 or more, check the box noted “Pretreatment Estimate” and complete 23 through 38. The completed claim form should be sent to Metropolitan **prior to the commencement of the course of treatment**. Metropolitan will review the claim (and any supplementary information required) and notify your patient of the benefits payable.

   A pretreatment estimate of benefits is not intended to preclude a course of treatment agreed upon by you and your patient. The intent is to avoid any misunderstanding concerning benefits payable under the dental plan. A pretreatment estimate is not necessary for oral examinations, cleanings, fluoride applications, dental x-rays or emergency treatment.

4. Generally, we do *not* request x-rays where standard filling materials are used. Pre-operative x-rays are requested *only* in connection with prosthetics, fixed bridgework, or case restorations. Occasionally we may request x-rays that relate to other dental services.

   In an effort to reduce your costs and any inconvenience, we request your cooperation in submitting x-rays *only* in the above mentioned circumstances or when specifically requested. This will also enable us to expedite the processing of a pretreatment estimate.

5. If authorized by the employee, benefit payment will be made directly to you.

**Mail completed form to:** **MetLife Dental Claims**
**P.O. Box 14093**
**Lexington, KY 40512-4093**

**Claim Inquiries:** **1-800-942-0854**